DOCUMENT RESUME

ED 083 504 CG 008 362

AUTHOR Fidell, Linda S.
TITLE Put Her Down on Drugs: Prescribed Drug Usage in Women.
PUB DATE Apr 73
NOTE 13p.;Paper presented at the Western Psychological Association Meeting, 12 April 1973, Anaheim, California

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS Attitudes; *Discriminatory Attitudes (Social); *Drug Abuse; *Females; Individual Needs; Medical Services; *Physicians; *Stereotypes

ABSTRACT

The medical interview was examined as a problem in two way communication, with selective perception and both patient and physician expectations operating. The potential influence of belief in the sex role stereotype on physician perception of the female patient and his prescribing of psychoactive drugs was examined. (Author)

ED 083504

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

Put Her Down on Drugs:
Prescribed Drug Usage in Women

Linda S. Fidell
California State University, Northridge

Invited address for the Western Association of Women Psychologists:
Presented at the Western Psychological Association Meeting
Anaheim, California, April 12, 1973

Most social institutions reflect in one way or another our deep-seated beliefs in the sex role stereotypes. These beliefs are usually supported by both the individuals who run the institutions and the individuals who use them. The medical establishment is no exception. Both patients and doctors doubtless subscribe to the sex role stereotypes.

In the areas of both mental and physical health feminists are comi.q to understand that men and women behave differently and are treated differently. Differences in mental health behavior have been investigated in the well known works of the Brovermanns (1970), Chesler (1972) and others.

Differences in physical health behavior are in part rather obvious and concern about some of them is spreading rapidly. Thus, women have begun to question the advice about sexual behavior given them by their gynecologists (Scully and Bart, 1973), the treatment women receive during labor and delivery, the lack of support for and information about breast feeding, the widespread belief in the influence of hormone shifts on behavior (Paige, 1971), the use of hysterectomy as a sterilization procedure when tubal ligation is

CG 008 362

FILMED FROM BEST AVAILABLE COPY

available and much less dangerous (Hibbard, 1972; Schulman, 1972), the assumptions made about menopausal women (Neugarten and Kraines, 1965) and, until recently, restrictions on abortion when contraception failed. Most of these concerns center on problems women have which are uniquely their own because they involve reproduction. I think many of the complaints are justified and I hope that reforms are promptly forthcoming. The requirements of women, in this case, coincide with the general pressures toward humanizing medical practice.

My concern is with much subtler differences in medical behavior of men and women on issues that are not directly related to reproduction. Let me point to a few items on the tip of what I fear is a very large iceberg.

A variety of medical practices which reflect the shared beliefs of both patients and physicians in the sex stereotypes may prove discriminatory under close scrutiny. An article in the Washington Post (April 12, 1972), for instance, indicated that women may be getting more than their share of frontal lobotomies. Patients who complain of chronic anxiety, tension and depression and who hold jobs which are less than intellectually demanding are viewed favorably as potential candidates for a lobotomy. Obviously those housewives who suffer from "the housewife syndrome" are prime candidates on both criterial measures.

A Report of the Women's Action Program (DHEW, 1972) said that, "Research evidence indicates that sex role stereotyping influences the assignment of patients to diagnostic categories," and that,

"Physicians may be more likely to dismiss women's symptoms as neurotic or as 'normal' female problems, sometimes until physical diseases are beyond treatment," (p. 48) And although firm evidence in support of these claims is currently lacking, anecdotal evidence is readily available. We've all heard about the pregnant woman given tranquilizers for a neurotic rash that turned out to be from poison oak, or the housewife with a brain tumor diagnosed as neurotic and treated with tranquilizers until shortly before her death, and so forth.

But what are the differences in behavior between female and male patients that may lead physicians to erroneous diagnoses? Do, in fact, physicians misdiagnose the problems of women at a greater rate? Apart from reproduction, are the health problems of men and women different? Do physicians view patients of different sexes differently? Are the patients then treated differently? What pressures does the medical establishment provide for differential treatment of women and men?

Some differences in the health seeking behavior of men and women are well known. Women, for instance, visit physicians more frequently (Physician Visits, DHEW, 1972) report more symptoms on each visit (Gurin et al., 1960) and receive a greater percentage of both psychoactive and nonpsychoactive drugs (Rogers, 1971). One might expect these three variables to be related, as indeed they are. Since physicians tend to terminate interviews by giving prescriptions (Muller, 1972) it isn't surprising to find

the sex with the greater number of visits getting the greater number of prescriptions. The problem is that the numbers are disproportionate. Women get more drugs than they make visits. Therefore, a relationship that appears straightforward has, in fact, a heavy overlay of sex role stereotyping.

Let's look much more closely at the relationship between visits, symptoms, attitudes and drugs.

That women make more visits to physicians is an objective fact which has been related to the greater dependency needs of women. Yet a closer look at the numbers raises questions about the validity of this assumption. In absolute numbers, women make 58% of the visits, men 42%.[1] However, when visits to members of the obstetrics/gynecology specialty are subtracted, women make only 54% of the visits. Since women comprise 51.3% of the population, and comprise an even greater percentage of the population in the older age ranges when physicians visits are more prevalent, one wonders if women make more than their share of visits. A look at actuarial statistics is also revealing because, although women live longer, they also suffer from a higher percentage of disability at every age after young adulthood. Are women, then, making needless visits to physicians?

.....

1 The author was unable to determine if these percentages included health care delivered by the Veteran's Administration almost exclusively to men.

If, on the other hand, women do make an untoward number of physicians visits, it may be because the roles assigned to women make them sick. Bernard (1972) has shown that being married has adverse effects on the mental health and happiness of women (although it is apparently beneficial for men). Perhaps the role of housewife also has adverse effects on the physical health of women. Psychologists and others should keep in mind that social/behavioral variables may change physiology just as physiological variables may be related to changes in behavior.

One might also conclude from the drug usage statistics that women are both organically and functionally weaker than men. Women, it should be recalled, get 60% of the prescriptions for nonpsychoactive drugs and 67% of the prescriptions for psychoactive drugs. Both these prescription rates are disproportionate to the rates of physician visits, particularly in the psychoactive drug category. Chambers (1971) found that women were more heavily involved with the barbiturates, the non-barbiturate sedative-hypnotics, the relaxants and minor tranquilizers, the major tranquilizers, the antidepressants, pep pills, diet pills, the non-controlled narcotics, and the analgesics. Men were the major users of only marihuana/hashish, LSD, the inhalants, methedrine, and heroin. Put another way, somewhere between 45% and 50% of the women over 30 have used mood-modifying or psychoactive drugs in the last year (Mellinger, Balter and Manheimer, 1971; Linn and Davis, 1971). Women are heavily involved with drugs but, unlike men, their usage

appears legitimate because they tend to obtain drugs by prescription from a physician (Shapiro and Baron, 1961; Mitchell, Kirkby and Mitchell, 1970; Linn and Davis, 1971). Furthermore, people who obtain drugs from physicians tend to use them longer and more consistently (Mellinger, Balter and Manheimer, 1971).

But why are psychoactive drugs so popular with women and their physicians? Attempts to relate drug usage to both psychological/neurotic variables and demographic variables have been largely unsuccessful. We are left, then, with a curious void. In spite of the large numbers of persons involved, little is known about the factors which lead women to obtain and to use drugs.

Lets go back to the physician's office and sit in on a doctor/patient interview to try to determine what she's doing and how he's reacting to it. (Notice that there is no confusion about which one 'he' is and which one 'she' is.)

Female patients present more symptoms than do male patients. Zola (1966) examined the effects of presenting symptomology by looking at cultural differences instead of sex differences, but his findings are quite relevant here. His subjects were male and female Irish and Italian patients who presented themselves to the Ear, Nose and Throat Clinic at Massachusetts General Hospital. He matched pairs of Irish and Italisns by equating seriousness of illness and then examined differences in their presenting complaints and the reactions of physicians to those complaints. The two groups behaved quite differently. The Irish generally denied their illness, refused to admit pain, presented few symptoms in very specific locations and

stated that the illness was a problem for neither them nor their families. The Italians, on the other hand, were expansive in their descriptions of their illnesses, complained of pain, gave a larger number of symptoms in a variety of locations and acknowledged that their illness was a nuisance to themselves and their families. The physicians reacted to these differences by stating that the Irish, who were stoic, were more urgently in need of medical attention than the Italians, who were expansive, even though the cases were matched for seriousness of illness.

Women in this culture behave medically more like the expansive Italians while men, in general, act more like the stoic Irish. Women present physicians with a greater variety of symptoms, some of which are doubtless poorly specified. Not only that, but (at least on a checklist) women present more psychological symptoms while men present more purely physiological symptoms (Phillips and Segal, 1969). This is also reflected in the reasons women give for taking drugs: "headaches, nervousness, depression, lethargy, sleeplessness, or weight control," (Linn and Davis, 1971) or " 'couldn't get along," suddenly feeling hot all over, restlessness, insomnia, cold sweats, and feelings that nothing is worthwhile" (Shader, Binstock and Scott, 1968). People who are older and people of lower social status also seem to end up with more than their share of mood-modifying drugs.

One interesting side-note is that women who are heavily involved with barbiturates frequently first started using them after surgery for gynecological problems (Whitlock, 1970). Whether

this, like alcohol consumption in women, stems from a need to reaffirm one's femininity (Wilsnack, 1973) or whether other factors are relevant is not known. However, one experiment (Brink, 1972) on drugs given during detoxification for heroin abuse showed that women get more drugs and a greater variety of drugs while hospitalized. If women who are hospitalized for other reasons also receive heavy doses of a variety of drugs, then those individuals who are susceptible to drug influences may first discover their pleasures in the hospital setting.

The attitudes of the physician are also relevant to the decision as to whether or not to prescribe mood-modifying drugs. Physicians who are better educated, who hold pregressive views, who view the patient as a whole entity (Joyce, Lost and Weatherall, 1967), who are not authoritarian (Klerman, Sharaf, Holzman and Levinson, 1959) and who interact frequently with colleagues (Linn, 1971) tend not to prescribe psychoactive drugs. If, on the other hand, the physician is pessimistic about the outcome of treatment or feels anger toward the patient (Shader, Binstock and Scott, 1968) then drugs are likely to be prescribed. In this regard, it is interesting to note that when physicians were asked to describe "the typical complaining patient" - sex unspecified - 72% referred spontaneously to a woman, 4% spontaneously to a man, and 24% did not mention the sex of the patient (Cooperstock, 1971). And if, during medical training, many physicians get into the habit of referring to women patients under 50 as 'douche bags' and women

patients over 50 as 'the crock' (as is done in one leading medical school) it is hard to see how the problems of women could be taken very seriously.

Physicians also apparently keep the role stereotypes firmly in mind when prescribing because they state their willingness to give tranquilizers to a housewife who can always take a nap and needn't be mentally alert, anyway (Prodsky, 1971). In another study, 87% of physicians judged daily use of Librium as legitimate for housewives, but only 53% thought daily use by a student was legitimate (Linn, 1971). Physicians, like many women, may hold pessimistic views of the general outlook for women in this culture.

And lastly, of course, comes the pressure from the drug advertisers who spend about $4,200 per physician per year to promote sales (Rogers, 1971). The trend in advertising is to define more and more of life's trials as appropriate for drug therapy (Lennard, Epstein, Bernstein and Ransom, 1970) in an effort to broaden the scope of problems for which psychoactive drugs may be legitimately prescribed. The trend is particularly obvious, I think, in advertisements which depict female patients.

Prather and I (1972) did a content analysis of drug advertisements in several leading medical journals over a five year period. We discovered the following differences in the way men and women were depicted in the advertisements:

1) The sex stereotypes were confirmed virtually without exception in the advertisements.

2) There was a strong tendency to associate psychoactive drugs with female patients (although not out of proportion to the prescription rates).

3) Nonpsychoactive drug advertisements usually showed a male as the patient, despite the fact that women also take more nonpsychoactive drugs than do men. I find this difference particularly insidious because it indicates that 'real' illnesses are had by men while mental problems are shown by women.

4) The symptoms listed for male and female users of psychoactive drugs were significantly different, with men usually presenting specific and work-related symptoms while women complained of diffuse anxiety, tension and depression.

5) Male patients were shown as older on average and at a wider variety of ages than female patients.

6) There were also tendencies to show women as recuperating from mental illness when they reassumed sex-stereotypical attitudes, as irritating significant others by her illness, and as suffering from socially embarassing symptoms.

We don't know how strong the effects of the differences in advertisements are on physician and patient attitudes, but we are very sure that they do nothing to dispell the strong beliefs in the sex stereotypes held by both. I suspect that the advertising along with the various other factors I've discussed here contribute to differential treatment of and differential behavior by women and men in the medical setting. And I suspect that the differences in this setting, like the differences in other institutions, rarely work in the best interests of women.

References

Bernard, J. The Future of Marriage. New York: World Publishing Company, 1972.

Brink, P. J. Behavioral characteristics of heroin addicts on a short-term detoxification program. Nursing Research, 1972, 21(1), 38-45.

Brodsky, C. M. The pharmacotherapy system. Psychosomatics, 1971, 11, 24-30.

Brovermann, I. K., Brovermann, D. M., Clarkson, F. E., Rosenkrantz, P. S. and Vogel, S. R. Sex role stereotypes in clinical judgments of mental health. Journal of Consulting and Clinical Psychology, 1970, 34, 1-7.

Chambers, C. D. An Assessment of Drug Use in the General Population of New York State. 1971.

Chesler, P. Women and Madness. New York: Doubleday and Company, 1972.

Cooperstock, R. Sex differences in the use of mood-modifying drugs: an explanatory model. Journal of Health and Social Behavior, 1971, 12, 238-244.

Gurin, G., Veroff, J., and Feld, S. Americans View Their Mental Health. New York: Basic Books, 1960.

Hibbard, L. T. Sexual sterilization by elective hysterectomy. American Journal of Obstetrics and Gynecology, 1972, 112, 1076.

Joyce, C. R., Lost, B., and Weatherall, M. Personal factors as a cause of differences in prescribing general practitioners. British Journal of Preventive Social Medicine, 1967, 21, 170-177.

Klerman, G. L,, Sharaf, M. R., Holzman, M,, and Levinson, D. J. Some relationships between sociopsychological characteristics of resident psychiatrists and their use of drug therapy. Paper read at American Psychiatric Association Meeting, New York City, 1959.

Lennard, Epstein, Bernstein and Ranson, Hazards implicit in prescribing psychoactive drugs. Science, 169(2), 438-441.

Linn, L. Physician characteristics and attitudes toward legitimate use of psychotherapeutic drugs. Journal of Health and Social Behavior, 1971, 12, 132-140.

Linn, L. and Davis, M. The use of psychotherapeutic drugs by middle aged women. Journal of Health and Social Behavior, 1971, 12, 331-340.

Mellinger, G. D., Balter, M. B., and Manheimer, D. I. Patterns of psychotherapeutic drug use among adults in San Francisco. Archives of General Psychiatry, 1971, 25, 385-394.

Mitchell, K. R., Kirkby, R. J., and Mitchell, D. M. Note on sex differences in student drug use. Psychological Reports, 1970, 27, 116.

Muller, C. The overmedicated society: forces in the marketplace for medical care. Science, 1972, 17, 488-492.

Neugarten, B. L., and Kraines, R. J. "Menopausal Symptoms" in women of various ages. Psychosomatic Medicine, 1965, 27, 266-273.

Paige, K. The effects of oral contraceptives on affective fluctuations associated with the menstrual cycle. Psychosomatic Medicine, 1971, 33.

Phillips, D. L., and Segal, B. E. Sexual status and psychiatric symptoms. American Sociological Review, 1969, 34, 58-72.

Physician Visits: Volume and Interval Since Last Visit, United States, 1969. DHEW publication Number (HSM) 72-1064, 1972.

Prather, J. and Fidell, L. Put her down and drug her up. Paper presented at American Sociological Association meeting, New Orleans, August, 1972,

Rogers, J. M. Drug abuse by prescription. Psychology Today, 1971 5, 16-20.

Schulman, H. Major surgery for abortion and sterilization. Obstetrics and Gynecology, 1972, 40, 738.

Shader, Binstock and Scott Subjective determinants of drug prescription: A study of therapists attitudes. Hospital and Community Psychiatry, 1968, 19, 384-387.

Shapiro, S. and Baron, S. H. Prescriptions for psychotropic drugs in a noninstitutional population. Public Health Reports, 1961, 76, 481-488.

Scully, D. and Bart, P. A funny thing happened on the way to the orifice: women in gynecology textbooks. American Journal of Sociology, 1973, 78, 1045-1051.

Washington Post, April 12, 1972.

Whitlock, F. A. The syndrome of barbiturate dependence. Medical Journal of Australia, 1970, 2, 391-396.

Wilsnack, S. C. Femininity by the bottle. Psychology Today, 1973, 6(11), 39-45.

Women's Action Program, DHEW publication, 1972.

Zola, I. K. Culture and symptoms - an analysis of patients' presenting complaints. American Sociological Review, 1966, 31(2), 615-630.